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	155241	A. BUILDING 00 B. WING	08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

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F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: August 15, 16, 17, 20, 21, and 22, 2012 Facility number: 000145 Provider number: 155241 AIM number: 100275110 Survey Team: Beth Walsh, RN-TC Courtney Mujic, RN Karina Gates, Medical Surveyor Census Bed Type: SNF: 12 SNF/NF: 97 Total: 109 Census Payor Type: Medicare: 19 Medicaid: 69 Other: 21 Total: 109 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on August 28, 2012 by Bev Faulkner,RN	F0000	The facility is requesting a desk review for compliance.The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any vilation of regulation. This provider respectfully that the 2567 Plan of Correction be considered the Letter of Credible Allegation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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F0156 SS=A	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on on interview and record review, the facility failed to issue a required liability and appeals notice to a Medicare beneficiary informing him of his end date of coverage for 1 of 3 residents reviewed for liability and appeals notices. (Resident #120) Findings include: The liability and appeals notice issued to Resident #120 was requested from the Office Manager on 8/21/12 at 11:00 a.m. No information or documentation was provided. During an interview with the Executive Director on 8/21/12 at 3:00 p.m., he indicated the liability and appeals notice for Resident #120 could not be found.	F0156	156 1. Nothing can be done for this resident since the notice should have been given to him in February. We will follow the new policy that went into effect in May. 2. A system was put into place in May 2012 after that date all residents received their letters of NOMNC. Staff will be re-in-serviced on 9/11/12. 3. The department that is providing the skilled service will notify social service 72 hours in advance so scocial services can send the letter of NOMNC to the resident or responsible party. BOM will verify that a NOMNC letter has been given to the responsible party 48 hours hours inadvance of last Medicare day. 4. BOM will verify that she has a copy of the NOMNC letter signed by the responsible party at the end of medicare coverage date. Findings will be reported to the CQI committee ongoing for minimum	09/20/2012

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	During an interview with the Office Manager on 8/22/12 at 10:51 a.m., she indicated Resident #120 was no longer eligible for Medicare services effective 3/2/12 and should have gotten the liability and appeals notice by 2/29/12, at the latest. The policy provided by the Office Manager on 8/22/12 at 11:00 a.m. entitled "Checklist/Instructions for Issuing a Notice of Medicare Non-Coverage (NOMNC) Determination on Continued Stay" indicated, "When should notices be given? 1. Part A-End of Part A covered level of care with benefit days remaining. 2. Part B-End of all Part B therapy services (if the resident is receiving more than one therapy service at the same time, the notice is issued at the time of discharge of the last therapy." The policy also indicated if the NOMNC form was issued in person, the original needed to go to the business office. Via telephone, a copy of the NOMNC was to be given to the business office. When sent certified mail, a note was to be placed on the NOMNC form for the Responsible party to sign and date and to return a copy for the facility's records. 3.1-4(f)(3)		of 6 months.	

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and record review the facility failed to ensure a resident's body was appropriately covered in order to maintain her dignity for 1 of 1 residents reviewed for dignity. Resident #31. Findings include: Observation of Resident #31 on 8/17/2012 at 9:34 a.m., indicated she was sitting in her wheelchair in front of her room in the hallway. Resident #31 had just returned from the shower and was wearing only a hospital gown and her back and left side was uncovered and her skin was visible. She was sitting in the hallway for approximately 1 minute before being covered. Medical records staff member #2 came up to the resident and put a bath towel over the resident. An inservice 'resident's rights' quiz provided by the Director of Nursing (D.O.N.) on 8/21/2012 at 10:25 a.m. indicated, "2. The facility must	F0241	241 1. Resident #31 was taken to their room and dressed.In the future resident # 31 will be dressed in the shower room per policy. 2. Any resident requiring assist to shower has the potential to affected. Staff will be in-serviced by the SDC on facility policy that residents are to be dressed in the shower room on 9/18/12. 3 Unit Managers and nurses will monitor residents receiving showers to assure no residents leave the shower room not properly dressed daily. 4. DNS, ADNS, SDC will monitor units weekly at different times monday thru Friday. Weekend Manager will observe residents receiving showers for compliance. Anyone not following the policy will receive disciplinary action. DNS will report monthly to the CQI committee any findings ongoing for a minimum of 6 months..	09/20/2012

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	promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality? True." A document titled, 'Shower: Skills validation- CNA' with a review date of 04/2012 indicated, "18. Assist resident in dressing and comb hair. 22. Return resident to room." 3.1-3(t)			

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F0250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure vision services were provided for 1 of 1 residents reviewed for Pre-Admission Screening/Annual Resident Review (PASARR) services. (Resident #7) Findings include: The clinical record for Resident #7 was reviewed on 8/20/12 at 1:30 p.m. The diagnoses for Resident #7 included, but were not limited to: mental retardation, bipolar disorder, depression with adjustment disorder, and seizure disorder. On the Pre-Admission Screening/Annual Resident Review, dated 9/6/11, it indicated Resident #7 would benefit from routine vision evaluations. A Health Services Consent Form, dated 3/1/10, was provided by the DoN (Director of Nursing) on 8/21/12 at 10:00 a.m. It indicated on-site eye care services were denied by the	F0250	250 1 Resident #7 saw the eye doctor on August 22, 2012. 2. Any resident that has had a change in their POA have the potential to be affected. New vision consent forms have been sent to all residents responsible party with a letter requesting responsible parties to bring a copy of their POA or guardianship papers to the facility if they have changed in the last year. 3. A tickler system will be started with residents with current signed consents and as new consents arrive they will be added to the tickler system so that all residents are seen annually and prn for a eye exam. Social service will be in-serviced on 9/11/12 Social Social Service Consultant. 4 Medical records will do a monthly audited to compare who is due to be seen to who have been seen by the eye doctor. Medical records will report finding will be reported to the CQI committee monthly ongoing for a minimum of 6 months.	09/20/2012

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	previous Power of Attorney (POA). At 1:40 p.m., on 8/21/12, the DoN indicated the facility was unable to determine when Resident #7's last vision services appointment was. In an interview with Family Member #6 on 8/21/12 at 2:30 p.m., he indicated the facility called him that day to determine if he would like vision services provided for Resident #7 and he indicated he would like services provided at that time. Family Member #6 also indicated that he became Resident #7's POA about a year ago and was not sure why the previous POA denied vision services for Resident #7. He also indicated that day was the first day the facility asked him about any routine services. On 8/22/12, at 10:20 a.m., the Social Services Director (SSD) indicated when there was a change of POA for a resident, the Social Services Department would determine if the new POA would like to initiate previously denied services, like vision services, or if the POA would like to continue to deny the services. She indicated this type of discussion with the new POA, was done at the time of the change to a new POA or shortly after. The SSD also indicated			

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	the current POA for Resident #7, had been the POA for about a year. The SSD indicated she was unsure of why routine services were not discussed with the current POA until it was brought to their attention. 3.1-34(a)			

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F0272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on interview and record review, the facility failed to accurately assess a resident's dental status for 1 of 3 residents reviewed from the sample of 4 who met the criteria for	F0272	272 1.Resident # 50 will see the dentist on 9/14/12. The dentist will assess her dentures for proper fit. Resident # 50 has never complained about ill fitting dentures. Her family has	09/20/2012

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	dental status and services. (Resident #50) Findings include: The clinical record for Resident #50 was reviewed on 8/20/12 at 11:00 a.m. The diagnoses for Resident #50 included, but were not limited to: hypertension, diabetes, and depression. Review of the 6/20/12 quarterly MDS (Minimum Data Set) assessment indicated Resident #50 did not have loosely fitting dentures. During an interview with Resident #50 on 8/15/12 at 1:47 p.m., she indicated her dentures were loose, did not fit her, and had been that way for years. During a telephone interview with Family Member #7 on 8/22/12 at 1:15 p.m., she indicated Resident #50 had dentures for many years and always had problems with getting them to fit snugly. She also indicated that Resident #50 did complain about chewing. During another interview with Resident #50 on 8/21/12 at 10:24		requested no dental services in the past. 2 Any resident with dentures have the potential to be affected. Residents that have signed consent forms are seen yearly and prn. New consent forms were sent to all responsible parties to see if any responsible parties would like to add services for their resident. 3.Responsible parties will be able to continue to make the decisions on services they want their family to receive. Consent forms will be given to the responsible parties on admission and yearly. Current residents with signed consents will be put on a tickler system so that all residents will be seen annually and prn as new consents come in those residents will be added to the tickler system. 4. Medical records will compare residents that due to be seen each month to the dental progress notes. Medical records will report any findings to the CQI committee monthly ongoing for a minimum of 6 months.	

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	a.m., she indicated her dentures affected the way she ate in that she tended to eat less and had difficulty with chewing and biting. She also indicated her dentures slid around when she ate. When informed the information in her 6/20/12 quarterly MDS assessment did not indicate she had loosely fitting dentures, she indicated, "I don't know how they came up with that, but it doesn't surprise me." 3.1-31(c)(9)			

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F0279 SS=A	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review, and interview, the facility failed to ensure a hospice plan of care was developed in coordination with the hospice company for 1 of 1 residents reviewed for hospice. Resident #91. Findings include: Resident #91's clinical record was reviewed on 8/20/2012 at 9:30 a.m. Diagnoses included but were not limited to; depressive disorder, diabetes, hyperlipidemia, hypertension, atrial fibrillation,	F0279	279 1. Resident # 91 care plan will be reviewed and coordinated by hospice and the facility on 9/10/12. 2. All residents currently on hospice have the potential to be affected. All residents currently on hospice will have their care plans reviewed and coordinated on 9/10/12. 3. Any time a resident elects hospice services, hospice and facility will meet to coordinate care. Facility will invite hospice to attend facility care plan meetings for hospice residents. Staff will be in-serviced on 9/10/12 by hospice RN. 4. Social service will keep a record of who attends the care plan	09/20/2012

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	dementia, osteoporosis, delusional disorder, aphasia, neuropathy, insomnia. A MDS (Minimum Data Set) quarterly assessment, dated 6/20/2012, indicated Resident #91 received the following restorative nursing programs; range of motion daily. A care plan, dated 4/11/2012, indicated,"Problem: resident receives hospice services. Goal: Resident will experience death with dignity and physical comfort including maintaining optimal nutritional status and skin integrity as disease process allows. Advanced directive wishes will be honored. Approaches; Administer pain medication as ordered. Notify MD and hospice of unrelieved or worsening pain. Assess for signs of pain, both verbal and nonverbal, treat as indicated. Notify hospice when there is a change in the resident's condition. Provide basic comfort measures (i.e. touch, oral care, back massage, etc.)" A care plan, dated 4/9/2012, indicated, "Problem: resident requires hospice with diagnosis dementia. Goal: Resident will experience death with dignity and physical comfort including maintaining optimal		meetings. Social service will report monthly to the CQI committee and findings monthly, ongoing for a minimum of 6 months.	

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	nutritional status and skin integrity as disease process allows. Advanced directive wishes will be honored. Approaches; Be available for resident/family, answer questions, provide comfort and support. Notify hospice as needed. Involve resident in care and decision making to maximal potential. Notify hospice when there is change in the resident's condition. Provide basic comfort measures. Provide food and fluids for comfort." Resident #91's clinical record indicated hospice visits by the following disciplines; aide, RN, chaplain. Dates of visits (recent): 7/19, 7/23, 7/26, 8/2, 8/6, 8/9, 8/15, 8/16. Hospice aide visit notes indicated bathing and grooming care including shower provided. Also, range of motion exercises. Hospice notes indicated: Hospice aide visits once week, shower each visit, grooming each visit, nail care prn, safety checks each visit, nutrition: offer fluids. Skilled nurse: to assess pain, cardio/pulmonary, GI, urinary, skin, safety, nutrition and hydration, neuromuscular, and mental status during each visit. Interview with the Social Services Director on 8/20/12 at 2:50 p.m.,			

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	indicated the residents on hospice, with the exception of Memory Care residents, have their care plans developed solely by her or one of her assistants, she doesn't meet with anyone in order to develop their hospice plan of care, she just writes them herself. Interview with the Memory Care Facilitator on 8/21/2012 at 10:50 a.m., indicated she had to, "throw the hospice care plan together," because Resident #91 came back from the hospital on hospice, so it was unexpected and quick. She did have a meeting with the resident's sister, but not specifically with the hospice company. She doesn't usually write hospice care plans and did not know that coordination between the hospice company and the facility was necessary to write the care plan, that is probably something nursing would know. If there are any other residents in the future who are put on hospice, she will be sure to have a care plan meeting in order to ensure the hospice care plan is more specific in terms of who will be responsible for what type of care is to be provided to the resident. "The resident hasn't had double showers or anything, but it makes sense why we should coordinate with hospice to make sure			

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	that doesn't happen." Observation on 8/21/2012 at 12:22 p.m., indicated the resident had a visitor and was getting ready for the lunch meal. She was sitting up at the table and talking with with her guest. Her visitor asked one of the CNA's if she would provide the resident with nail care today, the CNA said that she would. Interview with LPN #1 on 8/21/2012 at 12:24 p.m., indicated Resident #91's shower schedule is Thursday and Sunday mornings, more frequently though because she gets them from hospice. Hospice comes in on Tuesdays and Thursdays minimally. Interview with CNA #3 on 8/21/2012 at 1:00 p.m., indicated the hospice aide will tell them when they've given the resident a shower. If it is a Thursday, it's hospice that will do the shower, even though this is her scheduled shower day. If for whatever reason hospice doesn't do it, then she would give the resident a shower. 3.1-35(a) 3.1-35(d)(1).			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to complete weekly skin assessments as care planned for 1 of 3 residents reviewed in a sample of 3 who met the criteria for non-pressure related skin conditions and failed to document assessment of a resident's dialysis access site every shift as care planned for 1 resident reviewed for dialysis. (Resident #50 and #11) Findings include: 1. The clinical record for Resident #50 was reviewed on 8/20/12 at 11:00 a.m. The diagnoses for Resident #50 included, but were not limited to: anorexia, hypertension, diabetes, and depression. An observation of Resident #50's legs were made on 08/15/2012 at 1:53 p.m. A large brown bruise/discoloration was observed covering the entire shin area of her left leg and a large, dark purple bruise	F0282	282 1. Residents # 50 is receiving weekly skin assessments and are documented in the clinical record. Resident #11 is having her access site monitored every shift and is documented on the TAR 2. All residents with fragile skin or receive dialysis have the potential to be affected. Skin assessments are completed weekly on all residents. Residents having dialysis access sites are being assessed every shift and documented on the TAR. 3. Staff will be in-serviced on 9/12/12 by SDC on completing skin assessments and following MD orders. Unit managers/designee will monitor TARs and skin sheets daily. 4 ADNS will monitor TARS and skin sheets weekly to assure they are completed and documented. ADNS will report any findings to the CQI committee monthly, ongoing for a minimum of 6 months.	09/20/2012

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	with lighter brown discoloration surrounding the bruise was observed covering the entire shin area of her right leg. Review of the 1/21/11 skin care plan, current through 9/21/12, indicated Resident #50 had fragile skin and bruised easily. An approach indicated on the care plan was to assess and document skin condition weekly and as needed. During an interview with the DON (Director of Nursing) on 8/21/12 at 12:42 p.m., she indicated skin assessments are to be done weekly for every resident. Review of the weekly skin assessments completed for Resident #50 indicated skin assessments were done on the following dates: 6/7/12 6/14/12 6/28/12 7/5/12 7/26/12 8/9/12 8/17/12 No information could be found in the clinical record to indicate skin assessments were done the weeks of			

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	6/21/12, 7/12/12, 7/19/12, and 8/2/12. During an interview with the Director of Nursing on 8/22/12 at 1:52 p.m., she indicated there was no information to indicate skin assessments were completed for Resident #50 the weeks of 6/21/12, 7/12/12, 7/19/12, and 8/2/12. 2. The clinical record for Resident #11 was reviewed on 8/21/12 at 12:00 p.m. The diagnoses for Resident #11 included, but were not limited to: renal insufficiency. The August, 2012 treatment orders for Resident #11 indicated, "Dialysis access right upper extremity nurse to initial every shift free of redness, swelling, warmth and drainage" effective 3/26/12. The 9/28/11 dialysis care plan, current through 10/27/12, indicated an approach beginning 6/7/12 was, "Assess dialysis access site every shift for excessive bleeding, drainage, swelling, redness, warth (sic), bruit/thrill. Document findings, report abnormals to MD and dialysis." Review of the clinical record did not			

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	indicate nursing was initialing or documenting assessment of the dialysis access site for Resident #11 every shift. During an interview with LPN #1 on 8/22/12 at 11:09 a.m., he indicated he usually documented when she was sent out to dialysis, but that he was not documenting every shift. During an interview with LPN #5, the charge nurse for Resident #11's unit, on 8/22/12 at 11:14 a.m., she indicated assessment of Resident #11's dialysis access site was documented in the computer daily when the resident came back from dialysis, but not every shift. She also indicated the way she ensured nursing was checking Resident #11's access site every shift was by auditing the treatment book daily. She indicated she did not notice that nursing was not documenting care of Resident #11's shunt site every shift. 3.1-35(g)(2)			

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F0464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. Based on observation and interview, the facility failed to provide for adequate space in the dining room on the memory care unit. This had the potential to affect 27 of 27 residents who eat in the dining room on the Memory Care Unit. Findings include: An interview with the Memory Care Facilitator on 8/21/2012 at 10:50 a.m., indicated the unit is lacking space and they had to be creative with the furniture in order to fit comfortably everyone in the unit. Observation of the lunch meal on 8/21/2012 at 1 p.m., indicated there wasn't enough space to maneuver around the common dining area in the memory care unit. LPN #5 asked Resident #73 if she needed a clear pathway. The chair Resident #73 had been sitting in was back to back with another chair at a different table. LPN #5 then proceeded to move away and	F0464	464 1. Residents have adequate space in the dining room. 2 All memory care residents have the potential to be affected.The dining room has been rearranged. 3The nurses station is being reduced in size, a sofa and a chest of drawers have been removed from the dining area. The tables have been rearranged to use the additional space. Residents in wheel chairs will be placed on the parameter only. This gives the residents ample room to move between tables. 4. The table arrangement will be monitored three times a day to assure proper placement by the nurses and weekly by the unit manager. Findings will be reported to the CQI committee monthly, ongoing for a minimum of 6 months.	09/20/2012

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	reposition three chairs in order for the resident to get out of the table and walk herself out of the dining room. It took LPN #5 approximately 30 seconds to rearrange the chairs so that the resident could get up out of her seat and leave the table. Interview with LPN#1 on 8/22/12 at 10:55 a.m., indicated all 27 residents in the unit eat in the dining room at the same time, no one eats in their room because they need to ensure the resident's safety. Interview with Resident #122 on 8/22/2012 at 11:00 a.m., indicated she believed it is too crowded in the common area, she enjoys sitting outside because it's much less cramped. 3.1-19(w)(4)(A) 3.1-19(w)(4)(B)			